

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 37758
Registrar's No. 232

FILED DEC 11 1948

Registration District No. _____

Primary Registration District No. 3058

1. PLACE OF DEATH:

(a) County ST. CHARLES
(b) City or town St. Charles, Missouri
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
325a Adams
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community _____ years, months or days

3. (a) PRINT FULL NAME William J. Loewnau

3. (b) If veteran, name war None 3. (c) Social Security No. _____

4. Sex Male 5. Color or race White 6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Frieda Loewnau 6. (c) Age of husband or wife if alive 60 years
7. Birth date of deceased November 22, 1887
(Month) (Day) (Year)

8. AGE: Years 61 Months 0 Days 1 If less than one day
hr. _____ min. _____

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation Florist

11. Industry or business _____

12. Name Emil Loewnau
13. Birthplace Unk.
(City, town, or county) (State or foreign country)
14. Maiden name Barbara Manz
15. Birthplace Ill.
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs. Frieda Loewnau
(b) Address 325a Adams, St. Charles, Mo.

17. (a) Cremation (b) Date thereof 11-27-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: Southern Funeral Home
(City, town, or county) (State or foreign country)

18. (a) Signature of funeral director _____
(b) Address 6322 S. Grand Blvd.

19. (a) 11-29-48 (b) Therese Hamilton
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County St. Charles
(c) City or town St. Charles
(If outside city or town limits, write "RURAL")
(d) Street No. 325a Adams
(If rural, give location)
(e) Citizen of foreign country? _____ (Yes or No)
If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month November day 23rd
year 1948 hour 7 minute 45 p. m.

21. I hereby certify that I attended the deceased from July 10, 1948, to November 23, 1948;
that I last saw him alive on November 13, 1948,
and that death occurred on the date and hour stated above.
Immediate cause of death Death secondary to coronary insufficiency
Duration 6 mo.

Due to _____

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____
Of autopsy _____

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? _____ (Specify type of place)
(c) Means of injury U

23. Signature L.R. McSweeney (M. D. or other) M.D.
Address St. Charles, Mo. Date signed 11-23-48

RECEIVED
District Health Officer No. 9,
District of Columbia
Date Filed DEC 9 1948

JUN 12 1949

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.